results of your improved adherence to medical asepsis not only will decrease the incidence of infection to your patients directly, it can also decrease the number of days in hospital—so imperative with hospital cutbacks and DRGs. Perhaps even more important, you as a role model will influence other members of the health team, patient and family, thereby encouraging, by example, all of us to improve. It's in your hands.

MARSHA MILTON ROBERSON, RN, MN
Assistant Professor of Nursing
Critical Care Specialist Program Director
Department of Nursing, Graduate Division
California State University, Long Beach
Long Beach, CA 90840

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Update on Tarasoff in California

TO THE EDITOR: The Tarasoff[1] decision in California has disturbed the mental health profession. Under that holding, liability to third parties for failure to warn of specific threats by a violence-prone patient was established. The duty was vaguely defined, however, and the activities to be undertaken to meet the duty have been almost impossible to carry out. Beyond that, privacy problems have arisen. A therapist reporting threats by a patient is violating the patient's confidentiality. Of course, when life or limb are threatened, such violation is quite justified. Unfortunately, patients often do not see it that way. Similarly, slander issues have arisen. The real problem is that a moral duty has been converted into a legal duty. This is really new law, as no relationship need exist between the professional and the injured party. In fact, this liability was extended early in 1985 when damages were awarded for emotional distress to the child of a person who witnessed an attack on the person.[2]

The "Rescue Doctrine," a well-established principle of the English/American law, is analogous and to the contrary. There is no duty to rescue under our system. No one disputes, however, a moral obligation. A liability problem, alluded to infra, led to the development of "Good Samaritan" statutes in most jurisdictions. Professionals who are willing to stop at the scene of an accident are immune under these statutes from liability except for gross negligence.

All of this could be construed as an advance for our civilization. After all, one might argue, what is the value of law if no underlying morality exists? Unfortunately, the enterprising legal profession has used the occasion to up the liability ante. A new actionable offense has been born. Insurance companies stand to profit substantially. The cost of these profits will be borne by the therapists—and passed on to the general public in the form of fee raises. Just when we are abhorring rising health costs, more grist is added to the mill.

A greater evil is also served. As a matter of fact, civilization is threatened by this rising tide of liability. Small municipalities are cancelling bus service. Certain small enterprises cannot get off the ground because insurance is too expensive. Citizens are refusing to serve on public bodies because they are afraid of being sued and insurance is too expensive. Many cannot afford to purchase any insurance because of escalating costs. Medical care may at times be compromised because of potential risks to practitioners. In general, people are deterred from certain creative or productive activities because of fear of suit. Certainly, there are advantages to that development. Safety may be increased. On the other hand, progress is too often sacrificed.

Some relief is in sight for affected psychotherapists. The governor of California has signed (September 1985) Assembly Bill 1133. This bill limits the liability of therapists toward third parties under certain circumstances. The duty to warn, under appropriate circumstances, is preserved—upon communication of a serious threat of physical violence against a reasonably identifiable victim—but a more feasible means of carrying out the duty is proposed. In essence, the bill provides for immunity from liability for a psychotherapist who fails to warn and protect from, or predict, warn of and protect from, a patient's threatened violent behavior, except where the patient has communicated to the therapist a "serious threat" of violence against a reasonably identifiable victim. The bill further provides that if a duty to warn and protect does exist, this duty would be discharged by the therapist making *reasonable* efforts to communicate the threat to the victim and to law enforcement authority. One must recall that in the original Tarasoff case, the therapist involved actually did call the authorities and tried to have the patient committed, but was still found liable.

I believe that the public is beginning to tire of an overdeveloped burden of liability, seemingly often designed by the legal profession to generate more litigation. The pendulum may be swinging the other way. I certainly would not favor abandonment of new protections that have evolved. The current legal climate, however, is antiprogress, generates impossible expenses for the public and puts an aura of anxiety around common daily events and activities. It is to be hoped that Assembly Bill 1133 will signal a shift in a healthy direction.

RONALD SHLENSKY, MD, JD
317 West Pueblo St
PO Drawer LL
Santa Barbara, CA 93102

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Bleeding Gastric Varices

TO THE EDITOR: An unusual and unappreciated cause of upper gastrointestinal bleeding is isolated gastric varices without esophageal varices. This anatomic condition has been reported due to splenic vein thrombosis,[1] splenomegaly[2] and even to a wandering spleen.[3] Bleeding gastric varices due to primary splenomegaly alone apparently have not been reported.

Report of a Case

Splenomegaly was noted in a 55-year-old man during an unrelated surgical procedure. The patient's progress was uneventful for six months, at which time the first of several episodes of profuse, painless upper gastrointestinal bleeding occurred. Endoscopy showed only gastric varices, and an isotope scan, computed tomography and selective splenic arteriography all showed only a homogeneously enlarged spleen with good venous outflow. Laparotomy exposed a massive spleen weighing 2,050 grams due to a "mantle zone"

lymphoma that had also involved hilar nodes and liver. There was no hepatic cirrhosis. Intraoperative portal pressure decreased from 16 cm to 5 cm of water after splenectomy. No bleeding episodes had occurred in the 12 months since splenectomy when the patient was last seen.

Isolated gastric varices are thought to result from elevated fluid pressure transmitted from the splenic vein through the connecting short gastric veins. Regardless of the fundamental cause of this increased pressure, splenectomy apparently relieves the varices and stops further bleeding. Diagnosis of bleeding gastric varices by endoscopy may be difficult, arteriography is often diagnostic but may allow false diagnosis of a tumor, and subsequent biopsy can lead to catastrophe.[4]

Massive splenomegaly is seen in a variety of diseases, including lymphomas and other infiltrative processes. As much as 55% of total blood flow can pass through such a spleen, constituting an arteriovenous shunt[5]; in our case, the high flow produced secondary gastric varices that bled profusely. Although the medical literature appears not to include reports of this condition, isolated gastric variceal bleeding should be considered in any patient with primary splenomegaly, and splenectomy may provide the cure.

JAMES J. NESTOR, MD
Department of Medicine
Kaiser Permanente Medical Center
900 Kiely Blvd
Santa Clara, CA 95051

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Overtreatment and Mistreatment of Wounds and Burns

TO THE EDITOR: Two surgeons were changing dressings on patients they had operated on two days before. In both cases the wounds had been uncontaminated and no drains had been used. The first surgeon donned cap, mask and gloves and used instruments to remove the old dressings and to wash around the wound with an antiseptic. Then he applied an expensive inner dressing of fine mesh gauze impregnated with an air-occlusive antibacterial ointment. On top of that he put additional dressings and lots of tape.

The second surgeon simply took off the old dressing on his patient, examined the wound and, finding it satisfactory, just left it open to the air.

The floor nurses and the infection control nurse think the first surgeon is wonderful and the second surgeon is sloppy. But which surgeon has the most wound infections? There really is not much difference but I have tried both methods and got fewer stitch infections with the open, dry technique. Germs don't grow in dry places.

Since many surgeons today do leave wounds open, particularly after the initial dressing, and since they have such good results, why should others go through all that rigamarole? And it may easily cost the patient $12 each time.

Well, these were clean and closed wounds, but what about open wounds such as deep abrasions, burns and small lacerations that have not been sutured? The conventional wisdom is to smear them up with an antibacterial cream or ointment and to occlude the oozing raw surfaces further with "ouchless" dressings that "won't stick."

We should ask ourselves why we use dressing at all. Animals recover from prodigious wounds without dressings and without clinical infections. They lick their open wounds to remove dirt and coagulum and to allow air into the deeper parts. Their saliva is far from sterile but cleansing, debridement and drainage is accomplished with usual success.

Cleansing, debridement and drainage—we can best accomplish these by soaking open wounds, including burns, two or three times a day, usually at home in the bathtub or shower or with a wet towel and by gently wiping with cotton or even a washcloth. No, we do not have to actually lick our wounds, but we do much the same in this way.

Our problem stems from the common belief that we must keep every germ *out* of such open wounds. The fact is that we cannot; skin cannot be sterilized anyway. Instead, we should concern ourselves with getting rid of the germs that are in there already. Tap water is not sterile but contains less than 1 millionth of the number of germs that can be found in pus. We should not be afraid to use it.

We should use simple gauze dressings sparingly and only to stop bleeding at the very first or to keep clothing from getting soiled where clothing must be worn. Such a dressing will come off easily when the patient is soaking it those two or three times a day.

With these principles, a number of us have found much quicker healing with less pain or discomfort, fewer hospital admissions and, of course, great savings.

GEORGE B. MARKLE IV, MD
911 N Canal Steet
Carlsbad, NM 88220

Osteoporosis and the American Diet

TO THE EDITOR: I read with interest the article on prevention of osteoporosis and osteoporotic fractures in the November 1985 issue.[1] There is considerable evidence to indicate that the typical American diet which is very high in protein may be a major factor in osteoporosis in this country. The breakdown products of a high protein diet are eliminated by the kidneys, causing excess loss of calcium. This risk factor is mentioned very briefly in the article. We have been led to believe in this country that high protein intake through meat and dairy products is essential to our well-being. Perhaps an emphasis on lower protein intakes would cut down on the risks of osteoporosis as well as of calcium-based urinary calculi.

IRA E. BAILIE, MD
Turlock Medical Clinic
1015 East Main Street
Turlock, CA 95380

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